

IAC Releases Cardiovascular Catheterization Accreditation Program

Working in concert, the Society for Cardiovascular Angiography and Interventions (SCAI), the Heart Rhythm Society (HRS), the Alliance of Cardiovascular Professionals (ACVP) and the Intersocietal Accreditation Commission (IAC) announce the release of the IAC Cardiovascular Catheterization accreditation program.

PAGE 34

Baylis Medical and Siemens Healthineers Co-Sponsor Physician Training for State-of-the-Art, Minimally Invasive Heart Procedure

Baylis Medical Company Inc. and Siemens Healthineers are co-sponsoring a first-of-its-kind training program aimed at helping cardiologists perform a complex procedure that is quickly becoming the gold standard for treating patients with atrial fibrillation and other structural heart diseases.

PAGE 34

EPLAB[®]

DIGEST

A PRODUCT, NEWS AND CLINICAL UPDATE FOR THE ELECTROPHYSIOLOGY PROFESSIONAL

NOVEMBER 2017 Vol. 17 No. 11



SPOTLIGHT INTERVIEW

PARAS HMRI HOSPITAL

*Prof. Dr. Narendra Kumar, MD, PhD, MCSE, FRCP-Edin, FACC, FESC
Arrhythmia and Pacemaker Clinic, Department of Cardiology, Paras HMRI Hospitals, Raja Bazar, Patna, Bihar, India*

Paras HMRI Hospital is the first corporate hospital of Bihar and Jharkhand. The 350-bed multispecialty tertiary care institute, with over 25 medical and surgical disciplines, is a state-of-the-art facility with the latest high-tech infrastructure and equipment, offering clinical services in the fields of oncology, cardiac sciences, neurosciences, orthopedics and joint replacement, nephrology, and emergency care, to name a few.

The doctors and nurses at Paras HMRI aim to deliver excellence to the more than 600,000 people of Patna as well as to the adjoining areas of Uttar Pradesh, Jharkhand, Nepal, and Bangladesh.

continued on page 12

Outsourced Remote Monitoring Speed Traps

*Jim Collins, CPC, CCC
Consultant, CardiologyCoder.Com, Inc.*

Morbidity and mortality benefits, reduced hospital admissions, reduced healthcare expenditures, and durable revenue streams are facilitated by remotely monitoring implanted cardiac devices. Specialty society statements^{1,2} establish that all implanted cardiac devices should be remotely monitored as soon as possible. Because Medicare penalizes re-admissions that take place within 30 days of discharge and remote monitoring is proven to prevent admissions, it is beneficial to initiate remote monitoring prior to discharge.

Remote monitoring has many

benefits, but it involves handling an overwhelming amount of data. Downloading this data and preparing it for physician review and interpretation constitute most of what is called the “technical component” (TC) of the service. The cost of internet, electric, rent, paper, and toner are also included in the technical component.

The “professional component” (PC) is everything that takes place after the data is assembled and ready for interpretation. This includes review of the data, interpretation of it, generation of a report, and authentication of the report.

continued on page 6

IAC Cardiac Electrophysiology Accreditation: Experience at St. Louis Children’s Hospital

Interview by Jodie Elrod

In this article, we learn more about how the pediatric EP program at St. Louis Children’s Hospital (SLCH) became one of the first two pediatric EP labs to receive IAC Cardiac Electrophysiology accreditation. George E Van Hare, MD is the Chief of Pediatric Cardiology, and Louis Larrick Ward Professor of Pediatrics at Washington University School of Medicine in St. Louis, Missouri. He also serves as Co-Director of St.

Louis Children’s and Washington University Heart Center.

What can you tell me about the pediatric EP program at St. Louis Children’s Hospital?

We have a very comprehensive program. We do everything that a pediatric cardiology and cardiac electrophysiology program does, including catheter ablations, device implantations, etc.

continued on page 10

WWW.EPLABDIGEST.COM

Outsourced Remote Monitoring Speed Traps

continued from cover

Medicare payment rates are based on the understanding that the billing physician is personally performing all these services. I will touch on more of this later in the article.

When physician office staff download data and prepare it for review, the physician can bill for the technical and professional components of the service. Billing becomes more complicated when the technical component of remote monitoring is provided by an outside vendor.

Without due diligence, physicians can enter relationships that violate multiple regulations enforced by Medicare, the Department of Justice, and the Office of Inspector General. Penalties can exceed \$50,000 per claim, sanction from Medicare, medical license revocation, and prison sentences of up to 5 years.

When considering outsourcing, keep the following issues in the forefront:

#1: Medicare's Anti-Markup Payment Limitation

According to Medicare Transmittal 455,³ "Anti-markup applies when a diagnostic service payable under the Medicare Physician Fee Schedule (MPFS) is performed by one physician/supplier and billed by another physician/supplier." The transmittal establishes that Medicare payment to the purchasing physician cannot be higher than the amount he/she paid to the organization that provided the technical component.

For example, if a third party charges \$20 for the technical component, then \$20 is the maximum charge the purchasing physician can submit to Medicare. If the purchasing physician were to bill and get paid the Medicare allowable of \$26, then he or she would make a profit of \$6 for each service purchased from the supplier. That \$6 profit is what the anti-markup payment limitation prohibits.



Jim Collins, CPC, CCC

In the early years of the anti-markup payment limitation, some organizations attempted to bypass the rule by establishing what Medicare would soon refer to as "Questionable Business Arrangements." In CMS Transmittal 135,⁴ Medicare clarified the following:

"attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her technicians who are employed, contracted, or leased. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used, and hiring out their staff to the physicians to meet the supervision requirement. The bonafides of such arrangements may be suspect and could be an attempt to circumvent the prohibition against the mark-up on purchased diagnostic tests. If you have any doubt that a particular arrangement is a valid relationship where the physician is performing or supervising the services, this should be investigated. The Office of the Inspector General

(OIG) has responsibility for investigating violations of §1842(n) of the Act."

I contacted a Medicare policy representative to solicit her opinion regarding third parties providing the technical component of remote monitoring. The Q&A follows:

Question: "Can a business lease off-site employees to a physician group to allow the group to bill for the technical component as if it were rendered in-house? The employees would follow guidelines established by the physician, there would be a contract specifying that the amount charged for the leased employees covers office space, supplies, equipment, etc. However, the fee charged to the physician group would be less than the Medicare fee schedule."

Answer: "The scenario that you have described would need to comply with the anti-markup payment limit rules."

#2: Partial Provision of the Professional Component

The technical and professional components are distinct parts of the remote monitoring service. As previously outlined, the technical component includes downloading data and preparing it for physician review. The professional component of the service includes reviewing the data, interpreting it, generating a report, and authenticating the report.

When an outside vendor analyzes the data and then generates reports for physician review and signature, it is performing a big portion of the professional component of remote monitoring. This could render the service not billable.

#3: Report Generation and Authentication

The Medicare Condition of Participation, Section §482.24(c)1, requires

that "All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided."⁵ In addition, "the hospital must have a method to establish the identity of the author of each entry" and the author must authenticate his or her entry through signatures, written initials, or computer signatures.

In their "Legal Documentation Standards" publication, the American Health Information Management Association (AHIMA) reinforces the need for legitimate medical record authentication by stating, "Every entry in the medical record must be authenticated by the author — an entry should not be made or signed by someone other than the author."⁶

In some scenarios, an employee of the remote monitoring company might be making an entry in the medical record and not authenticating it. When the physician signs it, he/she is indicating that the report was personally generated. In addition to violating the Condition of Participation, the physician's signature falsely establishes that the report was personally generated; this could be viewed as a false statement.

Under 18 U.S. Code § 1035 (False statements relating to health care matters), "It is a crime to knowingly and willfully falsify or conceal a material fact, or make any materially false statement or use any materially false writing or document in connection with the delivery of or payment for health care benefits, items or services."⁷ Violation of this rule is a felony that could result in medical license revocation.

Judicial rules of evidence, Joint Commission standards, and AHIMA standards also make it inappropriate for a physician to authenticate another person's entry in a medical record.

continued on page 8

Speed Traps

Continued from page 6

#4: Overseas Labor

Medicare publication MM5427 addresses arrangements in which the technical component of services is provided overseas. "Take Note: Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India."⁸

#5: Diagnostic Test Supervision Guidelines

According to the Medicare Claims Processing Manual,⁹ the "general supervision" requirement associated with the technical component of remote monitoring is defined as "the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician."

Transmittal 135 also establishes that, "The supervision requirement for physician billing is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location."¹⁰

#6: Federal Anti-Kickback Statute

This statute "prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a Federal health care program ... Criminal penalties for violation are a fine of up to \$25,000 and imprisonment for up to 5 years."¹¹

In addition to violating the anti-markup rule, arrangements that facilitate an ordering physician receiving \$6 in profit might also violate the Anti-Kickback Statute. Specifically, government agencies might interpret this as the vendor

saying, "refer patients to us and we will give you money." This is prohibited by the Anti-Kickback Statute.

#7: Billing Requirements

Technical services that are purchased in compliance with all of Medicare's rules must be reported in a unique way. Medicare's anti-markup rule (Transmittal 455)³ requires "The physician or other supplier furnishing the TC or PC of the diagnostic test must be enrolled in the Medicare program" and that "the billing entity must indicate the name, address and NPI (national provider identifier) of the performing physician in Item 32 of the CMS-1500 claim form. However, if the performing physician is enrolled with a different B/MAC, the NPI of the performing physician is not reported on the CMS-1500 claim form. In this instance, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician in Item 32 of the CMS-1500, or electronic equivalent, claim form. The billing supplier should maintain a record of the performing physician's NPI in the clinical record for auditing purposes."¹²

THE INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) OPTION

When an IDTF performs the technical component of remote monitoring, it will bill Medicare directly. Compensation for the technical component will go directly to the IDTF so there is no anti-markup issue. The concerns regarding partial provision of the professional service, report generation, report authentication, overseas staffing and anti-kickback still apply. There is also a practical billing concern that should be considered.

When an IDTF bills for the technical component of a service and the physician bills for the professional component, their claims are submitted separately. This means that the patient will receive two separate bills from two separate providers and need to write two separate checks to send to two separate addresses. This will happen 4 times a year for device patients, plus 12 times a year for heart failure and implantable loop recorder patients. Many patients have discontinued remote monitoring because of the out-of-pocket costs; doubling the number of times that they must deal with out-of-pocket costs may increase the rate at which patients choose to discontinue remote monitoring.

THE IN-HOUSE OPTION

Performing the technical component

of remote monitoring in-house avoids the concerns associated with outsourcing. The anti-markup rule, Anti-Kickback Statute, and diagnostic test supervision guidelines are not violated when the technical component is performed in-house. Because of this, physicians can personally bill for the technical component of the service and receive full compensation.

However, performing this service in-house requires considerable effort. Clinic staff frequently need to log into multiple device company websites to access remote monitoring data, download data summaries, print them for physician review, and then import the signed reports into the electronic medical record. Performing this task for every remotely monitored pacemaker, defibrillator, implantable loop recorder, and heart failure device can be labor-prohibitive for some device clinics.

Organizations can use various tools to help manage their datastreams and clinic workflow. One example is Murj (www.murj.com), a cloud-based platform that pulls data from each of the device company websites and displays it all on a single platform, in a universal format. It eliminates the administrative burden of logging into multiple websites and individually handling each patient's data. It also allows clinicians to scroll through previous device data, manage recalled devices, triage alerts and device problems for expedited physician analysis, and view analytics.

CONCLUSION

Remote monitoring offers many benefits for patients and providers alike. However, there are a few speed traps that clinics should beware of as they begin to offer the service. Outsourcing the technical component of remote monitoring requires compliance with multiple regulations. In-house provision of services requires adequate resources. ■

This article is not intended or should be viewed as legal advice.

Disclosure. Jim Collins is currently an Advisor for Murj, where he supported the development of a billing module.

References

1. Lindsay BD, Estes NA 3rd, Maloney JD, Reynolds DW; Heart Rhythm Society. Heart Rhythm Society Policy Statement Update: Recommendations on the Role of Industry Employed Allied Professionals (IEAPs). *Heart Rhythm*. 2008;5(11):e8-10. Epub 2008 Sep 24.

2. Mittal S, Piccini J, Avi F, Snell J, Dalal N, Varma N. Abstract 13944: Early Initiation of Remote Monitoring in CIED Patients is Associated with Reduced Mortality. *Circulation*. 2014;130:A13944.
3. CMS Manual System. Pub 100-08 Medicare Program Integrity. Transmittal 455. Department of Health & Human Services (DHHS)/Centers for Medicare & Medicaid Services (CMS). Published March 15, 2013. Available at <http://go.cms.gov/2yBMjk8>. Accessed October 22, 2017.
4. CMS Manual System. Pub 100-04 Medicare Claims Processing. Transmittal 135. DHHS/CMS. Published April 2, 2004. Available at <http://go.cms.gov/2yBiu35>. Accessed October 22, 2017.
5. State Operations Manual. Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. CMS.gov. Published November 20, 2015. Available at <http://go.cms.gov/1Ryqelk>. Accessed October 24, 2017.
6. Legal Documentation Standards. AHIMA. Published June 9, 2008. Available at <http://bit.ly/2h4FTjo>. Accessed October 24, 2017.
7. 902. 1996 Amendments to 18 U.S.C. § 1001. U.S. Department of Justice, Offices of the U.S. Attorneys. Published October 11, 1996. Available at <http://bit.ly/2yN8WSy>. Accessed October 24, 2017.
8. MLN Matters. CMS.gov. Published November 13, 2006. Available at <http://go.cms.gov/2lcYDC5>. Accessed October 24, 2017.
9. Medicare Carriers Manual. Part 3 - Claims Process. Transmittal 1725. DHHS/CMS. Published September 27, 2001. Available at <http://go.cms.gov/2ixZr3f>. Accessed October 24, 2017.
10. Medicare Claims Processing Manual. Chapter 13 - Radiology Services and Other Diagnostic Procedures. CMS.gov. Published November 10, 2016. Available at <http://go.cms.gov/2bNO2Wa>. Accessed October 24, 2017.
11. Resource Guide: Laws Against Health Care Fraud Resource Guide. CMS.gov. Published September 2015. Available at <http://go.cms.gov/2yJOZtP>. Accessed October 24, 2017.
12. Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - JA6733. CMS.gov. Published January 15, 2010. Available at <http://go.cms.gov/2gAmMNG> and <http://go.cms.gov/2y44Cu0>. Accessed October 24, 2017.

Jim Collins, CPC, CCC is a consultant at CardiologyCoder.Com, Inc. His Twitter handle is @CardiologyCoder and he can be reached at 518.320.4376 or at Jim@CardiologyCoder.com.